APPROVED 8/25/2014

State Employee Benefits Committee
Monday, July 21, 2014 at 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on July 21, 2014, at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, Director, OMB, SBO
Faith Rentz, Deputy Director, OMB, SBO
Alexis Bryan-Dorsey, OMB
Kelly Callahan, Office of the Treasury
Lisa Callaway, Pension Office
Emily Cunningham, Lt. Governor's Office
Dawn Davis, OMB, SBO
Chip Flowers, Office of the Treasury
Darcell Griffith, University of Delaware
Catherine Hickey, DOJ
Katherine Impellizzeri, Aetna
Geoffrey Klopp, DOC
Joe Moracco, HMS
Michael Morton, Controller General
Jennifer Mossman, Highmark DE
Daniel Mburu, OMB
Casey Oravez, OMB, Financial Operations
Amy Quinlan, AOC
Rebecca Reichardt, OMB
Sandy Richards, AFSCME Retirees
Carrie Schiavo, Delta Dental
Aaron Schrader, OMB, SBO
Holly Scott, PHRST
Jim Testerman, DSEA-R
Chris Ulrich, University of Delaware
Jennifer Vaghn, DOI
Valerie Watson, Department of Finance
Stuart Wohl, Segal
Howard Atkinson, Segal

Introductions/Sign In
Director Ann Visalli called the meeting to order at 2:00 p.m. Anyone who had public comment was invited to sign-in and any others wishing to comment would be given the opportunity at the end of the meeting. Introductions were given around the room.

Approval of Minutes
Director Visalli requested a motion to approve the minutes from the May 16, 2014 SEBC meeting. Emily Cunningham made the motion and Controller General Morton seconded the motion. Upon unanimous voice vote the minutes were approved.

Director's Report – Brenda Lakeman
The IRS requires employers that offer the Flexible Spending Account program covered under Section 125 (Pre-tax insurance premium deductions), to perform a series of tests to assure that the plans comply with nondiscrimination requirements as set forth by the IRS. Testing is done in January after enrollment and periodically throughout the plan year. In June, the State plan failed within the Dependent Care Eligibility Test. The last time the State plan failed this test was in 2006. The test is conducted to determine if highly compensated plan participants are participating at a level that exceeds 55% of all plan participants. ASI recommended reducing the plan year maximum to $4,500 for the highly compensated employees for purposes of the dependent care benefit and retest in August and November 2014 to ensure the plan will pass. All highly compensated FSA dependent care participants, who elected the maximum of $5,000 plan year maximum, were notified via phone call and a letter in early July, that beginning with their July 25, 2014 pay, that their FSA dependent care deduction would be reduced for the remainder of the plan year to reduce their annual election to $4,500. This change impacted approximately 20 plan participants.

The upcoming DelaWELL 5KRun/Walk is scheduled for Wednesday, September 24 and registration is open.

The Annual Spousal Coordination of Benefits (SCOB) Non Compliance Audit reports were received from Highmark and Aetna on June 20, 2014. These reports contained 2,800 people who did not complete the SCOB form. Employees were notified via letters sent the week of June 30, 2014 that their spouse's coverage will be reduced to 20% pursuant to the SCOB policy until the form is completed and processed by their health plan carrier. Sanctions were applied on July 14,

2014 to spouses (actives and retirees) where the employee or pensioner had not completed and submitted a form by July 11, 2014. Once the form is received and it is determined that the State plan should cover the spouse as primary, coverage will be reinstated back to July 1, 2014. A postcard reminder to all employees and pensioners who cover a spouse is being considered for next year.

Group Health Financial Reporting – handout(s)
Ms. Oravez reviewed and discussed the Fund and Equity report for May 2014 and commented that the year to date balance was $5.9M with no substantial changes in May as April's balance was $5.7M. The June report will be completed in the next few days and preliminary estimates are that the ending balance is right around $9M. The reason for the increase is due to receiving a $4.8M rebate true-up payment that we were not expecting from Express Scripts.

Ms. Lakeman acknowledged that during the FY15 budget planning process, an $8M balance was projected for the end of FY14.

Director Visalli pointed out that when the rates were set for FY14, the SEBC voted to utilize surplus funds along with plan design changes and a modest rate increase.

FY14 Qtr 3 Financials (handouts)
Mr. Atkinson, Segal, reviewed the FY14 Third Quarter Financial Reporting. Year to Date - July 1, 2013 through March 31, 2014, the Group Health fund medical plans are experiencing a 0.8% surplus and the (Rx) prescription drug program is showing a (7.1%) deficit which has escalated when compared to recent time periods. For the period ending March 31, 2014 there is an overall (1.7%) deficit, compared to FY13 Third Quarter which was at an overall 0.3% surplus. This was expected as some surplus funds are being used to pay expenses.

Highmark and Express Scripts is where the majority of employees are enrolled with 19,000 in the PPO plan and 13,000 in the Blue Care HMO/IPA plan. The total experience for the Highmark plans show Highmark with a 0.6% surplus, a (7.4%) deficit for the Rx program and an overall (1.9%) deficit for the Highmark plans.

Aetna & Express Scripts show a 3.4% in medical surplus, a (1.3%) deficit for the Rx program and a 1.9% overall surplus in the Aetna plans. There are 2,500 active employees enrolled in the Aetna HMO.

The FY2013 financial analysis of health/Rx Plans show premiums are lower than the claim expenses. The claims experience between the Highmark and Aetna plans are similar.

Director Visalli commented that the higher deficits in the prescription drug program reflect experience through the end of March 2014 but it is important to note that the SEBC approved recent changes to the prescription plan effective July 1, 2014 in order to take action to drive down the costs. We will continue to monitor those changes that are intended to will help mitigate the deficit in the prescription drug program.

Mr. Atkinson commented the rates were set so that the combination of medical and prescription drugs will break even with exception of some buy down of surplus funds that was approved by the committee.

Discussion also occurred related to the volume discrepancy with so many enrolled in the Highmark plans and if enrollment volume was a factor in performance between the two carriers. Mr. Atkinson stated this was discussed a year ago, it was looked at and there was some slight demographic differences in terms of rating; however, as there is one overall rating for all the plans, there are going to be some discrepancies. The two carrier's plans are now running more in alignment with one another.

2014 Open Enrollment Overview – Faith Rentz

Since open enrollment closed, there have been a few changes in enrollment, most notably in the CDH Gold Plans as enrollment increased 8% increase for the Highmark plan and 9% for the Aetna plan. There was a slight 1% decline in HMO enrollment in both the Highmark and Aetna plans. The Comprehensive PPO plan is the richest plan offered and the one with the most enrollment which shows a slight 1% increase. There has been a significant decline of 7% in the First State Basic plan. We are seeing a shift in enrollment to the CDH Gold plans and Comprehensive PPO plan as people are moving away from the traditional HMO plans.

As seen in years past, employees appear to find much value in the dental and vision plans as there has been an additional 3% growth in the Delta plan and 5% growth in the EyeMed plan. There were about 200 additional contracts or enrollments in the Special Medicfill and that is most likely attributed to those moving into retirement.

New Express Scripts ID cards were mailed July 11, 2014 which replace the old Medco cards. Highmark Delaware IPA/HMO and PPO members as well as Aetna HMO members received new ID cards in mid-June to reflect the ER copay changes effective July 1, 2014. Aetna HMO new ID cards include new group numbers. Aetna members may experience a delay in claims processing due to Aetna's claims system conversion that occurred on July 1, 2014, yet this is expected to be resolved promptly.

There were pharmacy network changes effective July 1, 2014 where Express Scripts revised its pharmacy network. Ten pharmacies used by State of Delaware members are no longer in the network. These network changes were limited to 40 members who had specialty prescriptions filled at an affected retail pharmacy and 85 members filling non-specialty prescriptions at an affected retail pharmacy. All members were notified by letters mailed which contained several alternative pharmacies close to the member's home address.

Last September, the committee approved a two phrase approach to formulary changes. The first phase took place in January to move to the Express Scripts Basic Formulary and this impacted some drugs that have been in preferred status and moved to non-preferred which meant members were to see a higher copay when they get these certain prescriptions filled. The second phase of changes went into effect July 1, 2014 when the State's plan moved to the Express Scripts National Preferred Formulary. Many of those medications moved to non-preferred status in January are now excluded from the drug formulary. We have been notifying those impacted members since December through a series of communications about those changes. The Statewide Benefits Office has only received a few concerns received about these changes.

Additional enhancements are being implemented to the Compound Coverage Management Program which the committee approved in March 2014. Initially, the program covered 5 compound ingredients that were not FDA approved. If a script came into the pharmacy with one of these ingredients, the fill would be stopped and the script would not be approved because it contained a non FDA approved ingredient in the drug. Express Scripts has been working diligently to resolve this issue as they are seeing massive amounts of non FDA approved compound ingredients coming through in prescription medications. Express Scripts has added additional compound ingredients to the list. This would be a $2.5M estimated annual savings compared to the previous savings of $450,000 to the plan. There could be alternative medications or over the counter medications to be used in place of those non approved compound ingredients. Those members that are impacted will be notified by mail that those drugs will no longer be filled.

Legislative Updates – Brenda Lakeman

A few changes have been made to Section 21 of the FY15 budget epilogue which for number of years has prohibited new participating groups from joining the Group Health Insurance Program. This section has been changed to indicate that new groups can elect to join the plan with coverage effective January 1, 2015 if notification is received by September 1, 2014 so there is adequate time to set up their group(s) and process enrollment information. If new groups want to join after January 1, they must provide a four month notice. No letters have been received as of this date but based upon past interest; we do anticipate adding some towns, municipalities and fire companies in the future.

Director Visalli commented that the new groups permitted to join are outlined in existing code language. The moratorium for new groups to join had been in place to allow the Group Health Insurance Program to evaluate and determine the best approach to manage costs and administration for these outside participating groups.

Ms. Lakeman stated that all existing participating groups have signed an agreement which we have not had in the past and which is intended to outline basic expectations with regards to participation in the State's plan and to specifically address that groups that choose to leave the plan cannot return for three years. Any new groups will need to sign this same agreement.

Ms. Lakeman shared the 2nd piece of epilogue that is in Section 22. With the passing of Senate Bill 21 which added employee representation through a union coalition member to the SEBC, the SEBAC has been inactivated. All SEBAC members have been notified by the Statewide Benefits Office as well as by the Governor's office. Former SEBAC members have been encouraged to give public comment and attend SEBC.

House Bill 336 mandates an offering of a Supplemental Benefits package to employees consisting of accident, cancer and critical care and recovery insurance and Statewide Benefits Office will be releasing a Request for Proposal (RFP) for these benefits in mid-September. The contract effective date will be July 1, 2015. More information will brought to the committee during the RFP process.

Request for Proposal (RFP) Updates – Brenda Lakeman

A Life Insurance RFP process is underway and bid responses have been submitted by three bidders that include: Prudential, MetLife and Minnesota Life. Follow up questions have been sent to determine if the bidders meet the minimum qualifications for the finalist interviews scheduled August 26. The Proposal Review Committee will score the finalists and develop a recommendation to the SEBC on September 11. It is anticipated that the recommendation for contract award will be brought to the committee in September. The contract effective date will be July 1, 2015 and will change the life insurance plan year from the current January/December plan year to align with the plan year in place for medical, dental and vision coverage.

An EAP RFP will be advertised in October 2014 for a contract effective date of July 1, 2015.

As mentioned earlier, a Supplemental Benefits RFP will be release in mid-September for a contract effective date of July 1, 2015.

Ms. Rentz discussed the Flexible Spending and Pre-Tax Commuter (PTC) RFP Award Recommendation (handout). This coverage is currently through ASIFlex and expires December 31, 2014. An RFP was released on February 17, 2014 for an effective date of January 1, 2015. The scope of services for this RFP included administration of all aspects of the FSA and Pre-Tax Commuter (PTC) programs to comply with IRS requirements; optional debit cards for participants and secure on-line remote access to employee/participants' accounts. Additionally, interested bidders were required to demonstrate that they could accommodate the Delaware PTC program that includes the van pool program and direct pay accounts with parking vendors in the Wilmington area. On March 24, 2014, two bid responses were received from two vendors – ASIFlex and TASC. The PRC met on June 16 and evaluated the bid repsonses, interviewed bidders and scored both vendors. ASIFlex scored considerably higher. The PRC recommended to the SEBC that the contract be awarded to ASIFlex subject to negotiation of performance guarantees and the contract for a period of three years with two one-year renewal options beginning January 1, 2015.

Director Visalli stated the committee would take the vote after public comment and asked for any questions on the recommendation. There were no questions.

DelaWELL Health Management Program (handout) - Aaron Schrader

Ms. Lakeman stated that this is the fifth and final year of Alere's contract. Alere is the administrator of the DelaWELL health management program. With the award of this contract in 2010, disease management was moved from under the

medical carrier's administration and along with wellness, awarded to Alere. As part of evaluating the success of this model and determining a strategy to increase utilization of this program moving forward, the Committee will need to decide whether to initiate a RFP to continue to keep these services under the administration of a separate vendor or take another direction.

Mr. Schrader reminded the SEBC that this is the final year of Alere's contract (July 1, 2014 – June 30, 2015) with no additional contract renewal options. The Committee currently has the option to integrate this wellness/disease management program back under the medical carriers (Highmark Delaware and Aetna) which is the recommendation of the Statewide Benefits Office. This recommendation has value as both carriers offer similar quality programs, services and reporting with the ability to provide cohesive communication to the members which would create an enhanced member experience. Estimated FY16 DelaWELL program health management costs with the medical carriers versus FY15 Alere's estimated pricing is shown below:

Vendor	No. of Eligible	Estimated Costs
FY15 – Alere's Pricing	43,000	$2.3M
FY16 – Highmark	40,300	$2.3M
FY16 - Aetna	3,400	$311,000
FY16 Estimated Total		$2.6M

The suggested transition timeline
- August/September 2014 – planning and strategy discussions
- October 2014 – February 2015 – development of FY16 action and communication plan and timeline
- March 2014 – July 2015 – transition plan completed; implementation of communication plan and transition of members enrolled in condition care (disease management)
- July 2015 - implementation of integrated health management model and rewards program that would be directly tied to the member's medical plan enrollment.

Discussion occurred that this makes sense to roll the health management program into the two health plan carriers medical plan administration. The area of wellness and disease management has evolved in recent years and this approach allows for a better user experience. This move will help streamline single sign-on methods for members when accessing the health management program within their current health care provider versus working with multiple vendors.

Director Visalli stated the new integration to the medical carriers may get members more involved in their overall health management.

Ms. Watson suggested a diverse group of incentives may help interest those people that are not overly excited about the current incentive of $200. Ms. Lakeman will review the possibility of different incentives.

Further discussion on the value of the contract (shown in chart above) occurred. When the Medical RFP was released several years ago, the bidders were required to include their wellness and disease management capabilities and costs within their bids so the SEBC had the option to include these services as part of the member's medical benefit rather than providing them as a separate benefit option.

Treasurer Flowers expressed concern about the outcome of a competitive RFP being released now for health management for a July 1, 2015 effective date and the period of time left on Highmark and Aetna's contract (medical plan carriers) which is two years. The SEBC could then re-evaluate the possibility of bringing medical and health management back together as part of a bid process in 2016. He expressed concern that the medical benefits and plan administration are contractually in place now and attempting to mirror the health management program within the medical benefit

without receiving competitive bids from other vendors who may perform these services for two years could produce a different financial outcome to the Group Health Insurance Program.

Director Visalli reiterated that the health management option exists in the current contracts with Highmark and Aetna but the health management option has not been implemented. As the Alere contract comes to an end, the Committee has the option of implementing these services under the medical plan carriers for July 1, 2015 rather than releasing a separate RFP at this time. The next RFP for medical plan administration will include this option as the last RFP did.

It was agreed that further discussion would occur offline to address Treasurer Flower's concern.

Director Visalli stated that the voting on this subject would be deferred until August.

Ms. Vaughn inquired if the FY16 $2.6M total estimated expenses from Highmark and Aetna was a firm estimate. Director Visalli responded that more information could be provided at the next meeting.

Public Comment
Mr. Testerman expressed disappointment over the SEBAC no longer actively participating.

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Director Visalli asked for a motion to approve the FSA recommendation as stated in the handout and reviewed with the Committee. Controller General Morton made the motion and Emily Cunningham seconded. Upon unanimous voice vote the FSA recommendation was approved.

Director Visalli reminded everyone that the next SEBC meeting would be on Monday, August 25, 2014. Director Visalli asked for a motion to adjourn the meeting. Valerie Watson made the motion and Controller General Morton seconded. With unanimous voice approval the motion carried. The meeting adjourned at 3:08 pm.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB
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